

Michigan Department of Community Health  
**Board of Social Workers**  
P.O. Box 30670  
Lansing, Michigan 48909  
(517) 335-0918

## **SOCIAL SERVICE TECHNICIAN REGISTRATION INSTRUCTIONS**

Authority: P.A. 368 of 1978, as amended  
This form is for information only.

**NOTE:** It is your responsibility to have all the required documentation sent to the Board of Social Workers. Questions regarding your application can be directed to the Michigan Board of Social Workers at (517) 335-0918 three weeks after the date you sent the application. Applications submitted without the applicant's signature and date will be returned. Please allow 4-6 weeks processing time.

**INSTRUCTIONS FOR LIMITED SOCIAL SERVICE TECHNICIAN REGISTRATION** (intended for someone with 2 years of college that did not include 4 courses in human services and who still must acquire 2,000 hours of social work experience)

Applicants for Limited Social Service Technician registration must have completed two years of college in any subject and provide verification of either current employment or an offer of employment in the practice of social service.

1. Complete the application and return it to the Board of Social Workers with the appropriate fee.
2. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.
3. Read all instructions carefully and answer all questions on the application including providing details on a separate sheet if necessary. Failure to correctly complete the application in its entirety may delay the processing of your application.
4. Submit the *Certification of Social Work Education* form to your accredited educational institution for completion. The completed form must be sent to our office along with an official transcript from your educational institution verifying completion of at least 2 years of college.
5. Submit the *Supervisor's Verification of Social Service Employment* form to your supervisor for completion. Your supervisor must submit this form directly to this office to confirm current employment or an offer of employment.

**NOTE: LIMITED SOCIAL SERVICE TECHNICIAN REGISTRATIONS ARE VALID FOR ONE YEAR. THEY CAN BE RENEWED ONE TIME UPON VERIFICATION OF EMPLOYMENT.**

## **INSTRUCTIONS FOR SOCIAL SERVICE TECHNICIAN REGISTRATION**

Applicants for social service technician registration must meet **one** of the following:

- ◆ At least 2,000 hours of social work experience accrued over at least a one-year period under the supervision of a Licensed Bachelor's or Licensed Master's Social Worker **and** current employment in the field of human services or social services.
  - ◆ Successful completion of an associate's degree in Social Work that includes not less than 18 semester or 27 quarter hours of social work courses and a field placement or internship of not less than 350 hours under the supervision of a Licensed Bachelor's or Licensed Master's Social Worker.
  - ◆ Successful completion of 2 years of college (a minimum of 60 semester or 90 quarter hours) with at least 4 courses that are relevant to human services.
1. Complete the application and return it to the Board of Social Workers with the appropriate fee.
  2. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.
  3. Read all instructions carefully and answer all questions on the application including providing details on a separate sheet if necessary. Failure to correctly complete the application in its entirety may delay the processing of your application.
  4. If you do not currently hold a Limited Social Service Technician Registration and you are applying for registration by education, submit the *Certification of Social Work Education* form to your accredited educational institution for completion. The *Certification of Social Work Education* form must be sent directly to this office by your educational institution along with official transcripts. If you have a Limited Social Service Technician Registration, you do not have to re-submit your educational documentation.
  5. If applying for registration by experience, submit the *Supervisor's Verification of Social Service Experience* form to your Licensed Bachelor's or Licensed Master's Social Worker supervisor for completion. Your supervisor must submit the completed form directly to this office. A separate form must be submitted by your supervisor for each work experience/employment.
  6. If you have ever been registered/licensed in another state, a *Verification of Registration/Licensure* form must be received in this office directly from the other state(s). Forward the verification form to the licensing agency in each state for completion. The form must be returned directly to this office by the licensing agency.

## **GENERAL INFORMATION**

1. NAME AND/OR ADDRESS CHANGES: If your name and/or address changes please notify the Board of Social Workers in writing. To change a name or address, you can download the [Data Change/Duplicate License Request Form](#) from our website [www.michigan.gov/healthlicense](http://www.michigan.gov/healthlicense) and fax it to (517) 373-2179 or mail the form to Bureau of Health Professions, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes.
2. REFUND POLICY: If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Board of Social Workers in writing to request a refund.

NOTE: INITIAL SOCIAL SERVICE TECHNICIAN REGISTRATIONS ARE VALID FOR ONE YEAR OR LESS; SUBSEQUENT RENEWALS ARE FOR A THREE-YEAR PERIOD.

**Board of Social Workers**

P.O. Box 30670  
Lansing, MI 48909  
(517) 335-0918  
www.michigan.gov/healthlicense

**APPLICATION FOR A SOCIAL SERVICE REGISTRATION**

Authority: Public Act 368 of 1978, as amended.  
If this form is not completed, a license will not be issued.

**Type or Print Only****I AM APPLYING FOR THE FOLLOWING:**

☐ **Limited Social Service Technician Fee: \$ 40.00 71-6803-03**

☐ **Social Service Technician Fee: \$ 40.00 71-6803-01**

Your check or money order drawn on a US financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application.  
**DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Daytime Telephone Number
Street Address		
City	State	ZIP Code
All Previous Names and/or Birth Name Used (if applicable)		
Have you ever held a health professional license or registration in Michigan?		Michigan Registration Number and Expiration Date
<input type="checkbox"/> No <input type="checkbox"/> Yes		

**Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.**

1. Have you ever been convicted of a felony?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you been treated for substance abuse in the past 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you had one or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever had a federal or state health professional license or registration revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name

9. Do you hold or have you held a social services technician registration or license in any state(s)? ☐ Yes ☐ No  
 List each state, the license number, the date issued, and how it was obtained.  
**DO NOT LIST TEMPORARY LICENSES. You must have each state board verify licensure directly to this board office. (Attach additional sheets if necessary.)**

State	Permanent License Number	Date of Issue	Obtained by (Exam/Endorsement)

### EDUCATIONAL RECORD

Provide a chronological record of your educational preparation. Attach additional sheets if necessary.

Name and Address of College	Major Area of Study	Degree or number of years completed	Graduation Date

### SOCIAL SERVICE EXPERIENCE

**ALL QUALIFYING EXPERIENCE FOR LIMITED SOCIAL SERVICE TECHNICIAN MUST:**

1. Be verified by the supervisor on the separate Supervisor's Verification of Applicant's Social Service Experience Form.

**ALL QUALIFYING EXPERIENCE FOR SOCIAL SERVICE TECHNICIAN MUST:**

1. Have been completed under the supervision of a licensed bachelor's or master's social worker.
2. Be verified by the supervisor on the separate Supervisor's Verification of Applicant's Social Service Experience Form.

FROM: (Month/Day/Year)	TO: (Month/Day/Year)	EMPLOYER'S NAME AND ADDRESS	POSITION OR TITLE HELD	HOURS PER WEEK	SUPERVISOR'S NAME AND REGISTRATION NUMBER
					68-01-
					68-01-

### CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date
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**Board of Social Workers**

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[www.michigan.gov/healthlicense](http://www.michigan.gov/healthlicense)

**SUPERVISOR'S VERIFICATION OF SOCIAL SERVICE EMPLOYMENT**

Authority: Public Act 368 of 1978, as amended  
If this form is not completed, a license will not be issued.

**INSTRUCTIONS:** Complete Section I. Type or print your name exactly as it appears on your application. For completion of Section II, send this form to your employer. **This form must be submitted directly to the Michigan Board of Social Workers by your employer.**

**SECTION I - APPLICANT INFORMATION**

First Name	Middle Name	Last Name
U.S. Social Security Number		Date of Birth
Street Address		
City		
State		ZIP Code

Signature of Applicant	Date
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**APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO YOUR EMPLOYER FOR COMPLETION OF SECTION II ON THE NEXT PAGE.**

Name

**THIS SIDE TO BE COMPLETED BY THE EMPLOYER.**

Please complete the following information. Return this completed form directly to the Michigan Board of Social Workers at the address shown on page 1 of this form.

**SECTION II - CERTIFICATION OF EMPLOYMENT**

I certify that \_\_\_\_\_  
(Applicant's Name)

☐ is currently employed

☐ has been offered employment

at \_\_\_\_\_  
(Name of business/agency)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City) (State) (Zip Code)

The applicant's starting date of employment was/is: \_\_\_\_\_  
(Month/Day/Year)

The applicant's position is: \_\_\_\_\_  
(Title)

The applicant is supervised by: \_\_\_\_\_  
(Name of Supervisor)

\_\_\_\_\_  
(Title of Supervisor)

The supervisor is a Licensed Bachelor's or Licensed Master's Social Worker: ☐ Yes ☐ No

I declare that the information contained in this document is true and correct.

\_\_\_\_\_  
Signature and Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print or Type Name

**Board of Social Workers**

P.O. Box 30670

Lansing, MI 48909

(517) 335-0918

www.michigan.gov/healthlicense

**SUPERVISOR'S VERIFICATION OF SOCIAL SERVICE EXPERIENCE  
FOR SOCIAL SERVICE TECHNICIAN**

Authority: Public Act 368 of 1978, as amended.  
If this form is not completed, a license will not be issued.

**THIS FORM MUST BE SUBMITTED DIRECTLY TO THIS OFFICE BY THE SUPERVISOR(S) WHO IS VERIFYING YOUR SOCIAL WORK EXPERIENCE. IF SUBMITTED BY APPLICANT, IT WILL NOT BE ACCEPTED.**

A separate Supervisor's Verification of Social Work Experience form must be submitted for each work experience/employment.

The supervisor must be a Michigan Licensed Bachelor's or Master's Social Worker. If social work experience is gained in another state or country, the supervisor must hold a Master's or Bachelor's license in social work. If the supervisor does not meet one of these requirements he/she cannot verify work experience unless the Board has granted special permission.

Work experience requirements: At all levels, work experience must be earned following the completion of the educational requirements.

**INSTRUCTIONS TO APPLICANT FOR COMPLETING SECTION I:**

Complete Section I. Type or print your name exactly as it appears on your application and forward to your supervisor.  
A separate form must be used for each work experience/employment.

Please Print Clearly

Applicant's Name (Last, First, MI)		
Social Security Number	Telephone Number	
Street Address		
City	State	Zip Code

**Social Service Technician:** 1 year (2,000 hours) of experience in social work. An associate's degree in Social Work or the completion of 2 years of college with 4 human services courses waives the work experience requirement.

**INSTRUCTIONS TO SUPERVISOR:**

Type or print the remainder of this form and mail it directly to the Board at the address given above.

Supervisor's Name (Last, First, MI)	
Name of State in which you were licensed at the time you provided supervision to applicant	Registration/License Number
What was your level of Certification or Licensure at the time you provided supervision?	
What was the highest Social Work degree you held at the time of supervision?	
Applicant's Place of Employment (Organization Name)	
Applicant's Place of Employment (Complete Address)	
What was the applicant's title at the time of supervision?	

Name

### Supervisor's Social Work Licensure/Certification/Registration:

License/Certification/Registration held at time of supervision:
License/Certification/Registration number:
Issuing jurisdiction:
Date issued:
Years of post-degree practice experience:
Area of practice: <input type="checkbox"/> Macro <input type="checkbox"/> Clinical <input type="checkbox"/> Both

### Other Licensure/Credential if Supervisor is not a Bachelor's or Master's Social Worker:

License or credential held at time of supervision:
License or credential number:
Issuing jurisdiction or organization:
Did Board approve your special supervisory situation: <input type="checkbox"/> Yes - Date _____ <input type="checkbox"/> No

### Supervision Information:

Name of Agency/Employer at time of Supervision:		
<b>Agency Sector (Check only one):</b> <input type="checkbox"/> Private/Profit <input type="checkbox"/> Private/Non-Profit <input type="checkbox"/> Government <input type="checkbox"/> Other (Specify): _____	<b>Setting (Check all that apply):</b> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <input type="checkbox"/> Nursing Home  <input type="checkbox"/> Gov't Social Service Agency  <input type="checkbox"/> Employee Assistance Program  <input type="checkbox"/> Outpatient Facility/Mental Health Clinic  <input type="checkbox"/> Hospice  <input type="checkbox"/> Regional Treatment Center  <input type="checkbox"/> Research Setting/Consultant  <input type="checkbox"/> Group Home/Resident Facility         </div> <div style="width: 33%;"> <input type="checkbox"/> Hospital  <input type="checkbox"/> In-Home Services  <input type="checkbox"/> Court/Criminal Justice System  <input type="checkbox"/> Elementary/Secondary School System  <input type="checkbox"/> Other Social Service Agency  <input type="checkbox"/> Other (Specify): _____         </div> </div>	
Supervisor's Title:		
<div style="display: flex; justify-content: space-between;"> <div>Was this supervision completed for the applicant's registration?</div> <div> <input type="checkbox"/> Yes    <input type="checkbox"/> No         </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div>Is the applicant still employed by this agency/employer?</div> <div> <input type="checkbox"/> Yes    <input type="checkbox"/> No         </div> </div>		



Name
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**Applicant's Employment and Supervision Information:**

Applicant's job title during your supervision:
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Applicant's employer during your supervision:
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Date supervision began:	MM	DD	YY		Date supervision ended:	MM	DD	YY	
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Social Work functions performed by applicant: <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 45%;"> <input type="checkbox"/> Interviewing clients regarding client's situation  <input type="checkbox"/> Provide information about available services  <input type="checkbox"/> Provide assistance regarding community resources  <input type="checkbox"/> Encourage and provide linkages to available community services  <input type="checkbox"/> Conduct case-finding activities in community  <input type="checkbox"/> Monitor client's compliance with program's expectations  <input type="checkbox"/> Provide life-skills training         </div> <div style="width: 45%;"> <input type="checkbox"/> Other (Specify): _____         </div> </div>
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**Supervision Details:****Hours per week****Total hours**

Hours worked (16-40 hours/week)		
Face-to-face client contact		
All forms of supervision (total)		
Face-to-face supervision		
Telephone or teleconference supervision		
Individual supervision		
Group supervision		

Additional description of how supervision was conducted, if needed:
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I was present at the applicant's place of work.  If the applicant's work requirement was at a different site, please answer the following:  (1) Was there an equivalent supervisor on site?  I affirm that the content of the supervision has included:  (1) The transmission of social work knowledge, skills, values and ethics with specific application to the applicant's practice; (2) The standards of practice and ethical conduct with emphasis given to the social worker's role, appropriate responsibilities, professional boundaries and power dynamics; and (3) The applicant's permissible scope of practice.	<div style="margin-bottom: 10px;"> <input type="checkbox"/> Yes    <input type="checkbox"/> No         </div> <div style="margin-bottom: 10px;"> <input type="checkbox"/> Yes    <input type="checkbox"/> No         </div> <div> <input type="checkbox"/> Yes    <input type="checkbox"/> No         </div>
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Name
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**Supervisor:** Please send this form with your original signature to:

Michigan Department of Community Health  
Bureau of Health Professions  
**Board of Social Workers**  
P.O. Box 30670  
Lansing, MI 48909

If you have any questions, please contact this office at 517-335-0918.

**Supervisor's Declaration**

I declare that the information contained in this document is true and correct.

<b>Signature and Title:</b>	<b>Date:</b>
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Michigan Department of Community Health  
**Board of Social Workers**  
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www.michigan.gov/healthlicense

**CERTIFICATION OF SOCIAL WORK EDUCATION**

Authority: Public Act 368 of 1978, as amended  
If this form is not completed, a license will not be issued.

**INSTRUCTIONS:** Complete Section I. Type or print your name exactly as it appears on your application. For completion of Section II, send this form to the Director of your education program or the Registrar of the institution in which you completed your course work or social work degree. **This certification must be submitted directly to the Michigan Board of Social Workers by your educational institution along with a final official transcript.**

**SECTION I - APPLICANT INFORMATION**

First Name	Middle Name	Last Name
U.S. Social Security Number		Date of Birth
Street Address		
City		
State		ZIP Code
Name and Address of Educational Institution		Degree Awarded (if Applicable)
Date of Admission		Date of Completion

Signature of Applicant	Date
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**APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO YOUR EDUCATIONAL INSTITUTION FOR COMPLETION OF SECTION II ON THE NEXT PAGE.**

Name

**THIS SIDE TO BE COMPLETED BY THE EDUCATIONAL INSTITUTION.**

Please complete the following information. Return this completed certification **along with a copy of the applicant's transcript** directly to the Michigan Board of Social Workers at the address shown on the reverse side of this form.

**SECTION II - CERTIFICATION OF EDUCATION FOR SOCIAL WORK**

Name of Educational Institution

I certify that \_\_\_\_\_ attended the  
(Applicant's Name)

educational institution named above from \_\_\_\_\_ to \_\_\_\_\_ was granted  
(Month/Day/Year) (Month/Day/Year)

the following degree and/or completed the course work as checked below:

☐ Master's degree in Social Work granted on \_\_\_\_\_  
(Month/Day/Year)

☐ Bachelor's degree in Social Work granted on \_\_\_\_\_  
(Month/Day/Year)

☐ Associate degree in Social Work granted on \_\_\_\_\_  
(Month/Day/Year)

☐ This degree included at least 18 semester or 27 quarter hours of social work courses

☐ This degree included a field placement or internship of 350 hours of experience under the supervision of a licensed bachelor's or master's Social Worker.

☐ Two years of college education in an accredited college or university with the completion of at least 60 semester or 90 quarter hours.

☐ This course work included at least 4 courses relevant to human service needs.

\_\_\_\_\_  
Signature of Program Director

\_\_\_\_\_  
Date

( S E A L )

\_\_\_\_\_  
Print or Type Name of Program

If school has no seal, please indicate

Michigan Department of Community Health  
**Bureau of Health Professions**  
P.O. Box 30670  
Lansing, MI 48909  
www.michigan.gov/healthlicense

## VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

### PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

Check the profession for which you are requesting verification.		
<input type="checkbox"/> Chiropractic <input type="checkbox"/> Counseling <input type="checkbox"/> Dentistry <input type="checkbox"/> Marriage & Family Therapy <input type="checkbox"/> Medicine	<input type="checkbox"/> Nursing <input type="checkbox"/> Nursing Home Adm. <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Optometry <input type="checkbox"/> Osteopathy	<input type="checkbox"/> Pharmacy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Physician's Assistants <input type="checkbox"/> Podiatry <input type="checkbox"/> Psychology
<input type="checkbox"/> Sanitarians <input type="checkbox"/> Social Work <input type="checkbox"/> Veterinary		
First Name	Middle Name	Last Name
Previous Names Used	Date of Birth	U. S. Social Security Number
State Board	License Number	Date of Issue

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State. Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

### PART II: To be completed by the State Licensing Board.

Type of License:	Original Issue Date	Expiration Date
Basis for Issuance of License:		
<input type="checkbox"/> Examination - Please indicate type of exam (National, Regional, State, etc.) _____		
<input type="checkbox"/> Endorsement - Please indicate name of state _____		
License Status	Has the applicant incurred any formal or informal actions in your State?	
<input type="checkbox"/> Current <input type="checkbox"/> Lapsed <input type="checkbox"/> Inactive	<input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, Please attach certified copies of any actions.	
Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	

### CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Type or Print Name

( S E A L )

\_\_\_\_\_  
Title

\_\_\_\_\_  
Full Name of Licensing Board